Integrated Medical Services, LLC

PATIENT REGISTRATION FORM

Patient Name: _____ Date_____

DOB: ___ / / _____ Sex: M / F Donor: Y / N Ethnicity: Hispanic / Non-Hispanic

Religion: _____ Marital Status: Single / Married / Separated / Widow

SS: _____ _____ Phone: ( ) _____

Address: _____ Apt:

Facility: _____

City: _____ State: ___ Zip Code: _____

INSURANCE:

Primary Insurance Information: _____ (Medicaid / Medicare / BCBS#)

Policy / Member ID#: Group#: _____

Secondary Insurance Information: (Medicaid / Medicare / BCBS #)

Policy / Member ID #: _____ Group #: _____

_____

Person responsible for bill: _____ Phone: ( ) _____

(Person that pays Co-Pays or helps with additional cost)

POWER OF ATTORNEY/GUARDIAN:

Does patient have a Power of Attorne? Yes / No Legal Status P.O.A: _____

Name: _____ Relationship: _____

Phone: ( )_____

EMERGENCY CONTACT NAME:

Name: _____ Relationship: _____

Phone: ( )_____

The information provided above is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician / practice. I understand that I am financially responsible for any balance. I also authorize Integrated Medical Svcs, LLC or Insurance Company to release any information required to process my claims.

Patient
Signature: _____
Print Name: _____
Date: _____

Patient's Guardian
Signature: _____
Print Name: _____
Date: _____

MEDICAL HISTORY

1. Smoker: Never/former/current/heavy/light:
2. How many cigarettes a day?
3. Do you Drink Alcohol? Yes / No. if yes how much
4. Do you currently use illicit drugs? Yes / No
5. Have you ever used drugs in the past yes / no

LIST CURRENT AND PAST MEDICAL:

1. Major events: (surgeries, injuries, diagnosis)
2. Ongoing medical problems:
3. Are you seeing other doctors at this time? YES / NO Reason Medical / Mental
   Name phone# mental / medical
   Name phone# mental / medical
   Name phone# mental / medica

ALLERGIES:

1. Drugs -
2. Environmental:
3. Food:

FAMILY HISTORY:

1. MEDICAL (Diaseases, Diagnosis, Mental)

2. Social:
   Alcohol, drugs, finished school, ETC

Nutrition: is your Diet Poor, Fair, Healthy

DEVELOPMENTAL: Childhood Diseases (chicken pox, measles)

MEDICATIONS: PLEASE LIST YOUR CURRENT MEDICATION, NAME, DOSE, WHEN TAKEN

Charlotte D. Ballard, ENP-BC
6609 Blanco Rd Ste 360
San Antonio, TX 78216

PATIENT CONSENT FORM

Patient:_____ **DOB:**_____

All patients have the right to expect that all communication and records pertaining to their care should be treated as confidential. So that you may make a thorough examination and diagnosis, I understand you may need to obtain information from my medical doctors. Therefore I grant you the right to obtain information about my health (PPHI) from my medical doctors. I also give you permission to share my health information with other healthcare professionals, which include the release of records for the sole purpose of consultation regarding diagnosis treatment, planning and care.

CONSENT TO PHOTOGRAPH:

I am giving permission to have my picture taken for my electronic medical file.

INSURANCE AUTHORIZATION:

I authorize my Insurance Company to pay to the physician all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize physician to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance company.

PRIVACY ACKNOWLEDGMENT:

I have received a copy of the Notice of Health Information Privacy Practices as it pertains to use and distribution of my health records.

ATTENDANCE POLICY:

I am aware that if I do not comply with the attendance policy, I will be discharged from the practice. Policy consists of 3 missed appointments and failure to comply with my insurance guidelines and practice policies, will result in practice discharge.

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Date

: __

Integrated Medical Services LLC
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CONTROLLED SUBSTANCE MEDICATION

CONTROLLED SUBSTANCE MEDICATIONS are useful but have high potential for misuse and are therefore **CLOSELY CONTROLLED** by local, state and federal governments. Due to our physicians prescribing controlled medication, the **PATIENT** agrees to the following conditions: (a signed copy of this statement is filed in each patient's chart).

1. The patient is responsible for the controlled substance medications prescribed to them. If they prescription is: lost, stolen, misplaced, or if the patient has run out early, the prescription **WILL NOT** be replaced until their next refill.

2. Refills of controlled substances will only be made during regular office hours, Monday - Friday, in person, at the time of the scheduled office visit. Refills WILL NOT be made overnight, on weekends or on holidays. No refills for controlled substances will be made by a call in for lost, stolen, damaged, or misplaced medications. The Patient is responsible for taking medication as prescribed and keeping track of remaining amount. Police reports for stolen or missing medication **WILL NOT** be accepted.

3. If at any time any of the Practitioners feel that the patient is at risk for psychological dependence (addiction); the medication will no longer be prescribed.

4. The patient will be subject to Drug Screening.

5. Patient is to list their Pharmacy of choice, and that will the pharmacy used to refill any and all controlled substances. Should the patient choose to use another pharmacy, they must notify our office during their scheduled office visit. Failure to comply, will result in a 30-day notice before permanent termination.

_____ _____

Patient Signature Date

PLEASE NOTE; YOU ARE HEREBY ADVISED NOT TO DRIVE OR OPERATE HEAVY EQUIPMENT WHILE ON ANY CONTROLLED SUBSTANCE MEDICATION

Integrated Medical Services, LLC

Charlotte D. Ballard, ENP-BC
6609 Blanco Rd Suite
360 San Antonio, TX
78216

RELEASE OF MEDICAL RECORD(S) AUTHORIZATION

Patient:_____ **DOB:**_____

I, undersigned authorize the release of or request access to the information specified below for the medical record(s) of the above named patient.

Information to be Released / Accessed

Complete Medical Records (to include subjects below

__Billing Record
__History & Physical Progress Notes
__Lab / Pathology Reports
__ Radiology / Diagnostic Images Reports
__ Demographic / Insurance
__ Hospital Records
— Medication List
— Other_____

Information to be released to:

ATTENTION: _____

Integrated Medical
Services, LLC
6609 Blanco Rd Suite #360
San Antonio, TX 78216
Phone: 210-600-4105 Fax: records@ballardims.com

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to by disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including: treatment for alcohol or substance abuse, auto-immune deficiency syndrome {AIDS), related complex {ARC}, or human immune deficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent. I understand that I may be charged a fee for copies for my medical records.

Patient Signature _____ Date _____

Patient or personal legal representative (next of kin or legal guardian sign if the patient is a minor, legally incompetent or deceased)

Printed Name of Representative:_____

Relationship to Patient: _____

Integrated Medical Services, LLC

CONSENT AGREEMENT

By signing this Agreement, you consent to IMS (referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM/BHI Services are available to you because you have been diagnosed with (2) two or more chronic conditions which are expected to last at least (12) twelve months and places you at significant risk of further decline

CCM/BHI Services include 24-hour-a-day, 7 day-a-week access to a health care provider in the Provider's practice to address acute chronic care needs; systematic assessment of your care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a place of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services

PROVIDER'S OBLIGATIONS

When providing CCM/BHI Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM/BHI Services that are applicable to your conditions
- Provide to you a written or electronic copy of your care plan
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of revocation

BENEFICIARY ACKNOWLEDGEMENT AND AUTHORIZATION

By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM/BHI Services to you
- You authorize electronic communication of you medical information with other treating providers as part of coordination of your care
- You acknowledge that only one practitioner can furnish CCM/BHI Services to you during the calendar month
- You understand that cost-sharing will apply to CCM/BHI Services, so you may be billed for a portion of CCM Services even though CCM/BHI Services will not involve a face-to-face meeting with the Provider

BENEFICIARY RIGHTS

You have the following rights with respect to CCM/BHI Services:

- The Provider will provide you with a written or electronic copy of you care plan
- You have the right to stop CCM/BHI Services at any time by revoking this Agreement effective at the end of the current month. You may revoke this agreement verbally (210-608-6213) or in writing (CCN Medical Services, 6609 Blanco Rd #360, San Antonio ,TX 78216). Upon receipt of your revocation, the Provider will give you written confirmation to include the effective date of revocation

BENEFICIARY
Signature: _____
Print Name: _____

Date:

_____

BENEFICIARY'S REPRESENTATIVE
Signature: _____
Print Name: _____

Date:

_____